Baystone Limited

Cranford Nursing Home

Inspection report

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Exmouth
Devon
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15 April 2016
18 April 2016

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

Summary of findings

Overall summary

This inspection took place on 7, 15 and 18 April 2016 and was unannounced. Cranford Nursing Home is registered to provide personal care for up to 26 people. They provide care and support for frail older people. On the first day of our visit there were 15 people living at the home.

We brought forward this comprehensive inspection because we received concerns regarding the care provision and the staff levels at the service. We last visited the service in June 2014. The service was compliant with the standards inspected and no breaches of regulations were found.

In April 2015 the provider had made changes to their registration with the Care Quality Commission (CQC) and had removed two regulated activities. This meant they no longer provided a service for people with on-going nursing needs. People living at Cranford Nursing Home were now under a residential service contract and any nursing needs were being met by the community nurse team.

When we visited there was a registered manager in post. However their employment ended with the provider on the last day of our visit. They had applied to CQC to remove their registration. A registered manager is a person who has registered with 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 provider made us aware that the deputy manager and two senior care staff had also submitted their resignation. People and staff expressed concerns regarding the loss of the registered manager and other senior staff. The provider recognised the upset this had caused people and staff and were working to develop a stable workforce. They confirmed they were actively looking to recruit a new manager and senior staff and would keep CQC updated on the situation on a weekly basis.

There were adequate staffing levels to meet people's needs. Although people concerns were expressed regarding recent staff reductions and a proposed staffing level change. The provider confirmed this would not be something they would be considering in light of the staffing issues. Staff had clear leadership roles at the home with delegated responsibilities.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. The provider used the services of a care consultant to deliver training. Care staff had received training to take over some roles previously completed by nurses. Staff had developed skills and knowledge to meet people's needs. Staff relationships with people were strong, caring and supportive. Staff delivered care that was kind and compassionate.

Measures to manage risk were as least restrictive as possible to protect people's freedom. Medicines were safely managed on people's behalf.

Care plans were personalised and recognised people's health social and psychological needs. People's views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments had been completed and best interest decisions made in line with the MCA.

People were supported to eat and drink enough and maintained a balanced diet. People were positive about the food at the service.

The premises and equipment were managed to keep people safe. The provider was undertaking repairs and refurbishments.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. Where there were concerns or complaints, these were investigated and positive action taken.

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.

Reductions and loss of staff had caused uncertainty for people and staff at the service. The staff levels met people's needs when maintained at the levels scheduled.

People said they felt safe and staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

People's risks were managed well to ensure their safety.

There were effective recruitment and selection processes in place.

People's medicines were safely managed.

The premises and equipment were managed to keep people safe.

Is the service effective?

Good

The service was effective.

Staff received training which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well through contact with community health professionals.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People said staff were caring and kind.

Staff relationships with people were strong and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

Visitors were encouraged and always given a warm welcome.

People were able to express their views and be actively involved in making decisions about their day to day care, treatment and support.

Is the service responsive?

Good

The service was not always responsive to people's needs.

People had been encouraged to socialise and pursue their interests and hobbies, although this had recently stopped. The provider was introducing a new program of activities to re-establish leisure interests and socialisation.

Care plans were person centred about people's health needs, histories, wishes and social need. They guided staff how to appropriately meet their needs. Staff knew people's preferred routines.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had resigned from the service. People and staff said they had not been informed about the provider's plans regarding the future management at the home. They expressed concern about the lack of communication from the provider's.

People spoke positively about the registered manager and senior staff.

There was an effective audit program to monitor the safe running of the service with good quality monitoring systems in place.

There were measures in place to assess the quality and safety of

the service people received.

Cranford 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 was 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.

Cranford Nursing home is registered to provide personal care for up to 26 people. They provide care and support for older people.

This inspection took place on 7, 15 and 18 April 2016 and was unannounced. One adult social care inspector completed the inspection.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met and observed the majority of the people who lived at the service and received feedback from nine people who were able to tell us about their experiences. We also spoke with two visitors and a visiting district nurse to ask their views about the service. A couple of people using the service were unable to provide detailed feedback about their experience of life at the home. During the inspection we used different methods to help us understand their experiences. These methods included informal observation throughout the inspection.

We spoke and sought feedback from eight staff, including the deputy manager, senior care staff, care staff, catering staff and the administrator. We also spoke with the registered manager, both providers and a care consultant supporting the service.

We reviewed information about people's care and how the service was managed. These included two

people's care records and five people's medicine records, along with other records relating to the management of the service. These included staff training, support and employment records, quality assurance audits, minutes of team meetings and findings from questionnaires that the provider had sent to people, staff and health professionals. We also contacted health and social care professionals and commissioners of the service for their views. We received a response from two of them.

Requires Improvement

Is the service safe?

Our findings

People and staff expressed concerns there had been staff changes at the service. This had included the loss of a full time activity person, the registered manager and a kitchen assistant to undertake meal preparation in the evening. Staff said people had felt the loss of the activity person because they had spent quality one to one time with them. Staff also said they found the afternoon shift difficult without the kitchen assistant. This meant they had to stop supporting people with their personal care to ensure people had their supper. One care worker commented, "It is safe but I am worried if we have more clients and no more staff in the afternoons. We are expected to do the suppers if they cannot get cover for the three to seven shifts." The deputy manager said they had recognised the impact on staff at supper times and had planned for an additional staff member between three o'clock and seven o'clock. However, this had not always been possible due to recent high levels of staff sickness which had affected the majority of people and staff at the home.

People said they did not feel there were adequate staff at all times. They said they had to wait for staff to answer their bells but had their care needs met. Comments included, "Not enough staff, they answer the bell eventually, not always immediately. We have a lot oIf f agency staff. They cut the staff which means we have to have agency staff. I like to know who I am having."; "There are not always enough staff, they usually answer the bell in ten minutes."; "No there isn't always enough staff I have to wait about a lot… If I ring my bell it depends on the amount of staff they have got in, it is alright today."; "They have had lots of staff sickness, it could be better."

Staff levels scheduled on the rota included a senior carer on each shift with three care staff each morning, two care staff in the afternoon and one care worker at night. Staff said when they had their own team and had the scheduled staff allocated they could meet people's needs. The provider confirmed there had been a high level of staff sickness at the service caused by a severe viral infection in the local area. They had used local care agencies to try and maintain the staff levels but they had not always been able to cover at short notice.

On the first day of our visit a care worker had called in sick. Staff had contacted local care agencies and existing staff and had not been able to find cover. This meant staff were undertaking additional duties and were very busy. The senior care worker on duty was giving people their medicines, answering the telephone and front door. They also assisted with health professionals and assisted care staff to deliver personal care when possible. Staff confirmed they had met people's basis needs and people did not raise any concerns with us.

On the last day of our visit the atmosphere was calm. There was a full complement of scheduled staff which included a senior care worker and three care workers on duty, together with the administrator who worked three days a week. Staff although busy did not appear rushed and had time to meet people's individual needs. Staff said, "Today there are enough staff… we work as a team if we need help we ask for help.; "Today there are enough staff, having the agency staff has been upsetting and has cost a lot of money because staff have been sick."; "It is safe at the moment there are adequate staff levels, if any lower they

(people) would not be safe because of the type of residents who require two staff."

The provider said they were looking at a different staff level model. The registered manager expressed concern to the provider and us about the proposed new model. We discussed this with the providers. They said, "We are trying to get a more stable staff group and less reliance on agency staff, it is what staff and residents want. We have never wilfully understaffed we always request agency if someone is poorly and have agreed additional staff when advised they were needed." The provider confirmed at the inspection that they would not be making any changes to the staff levels. They said they would inform CQC before making any changes in the future to demonstrate how they had assessed people's needs to ensure they had adequate staff levels.

People when asked said they felt safe and supported by staff. Comments included "Very, I am not a scared person."; "Definitely feel safe."; "Yes, I don't demand much, I get on with things."; "They have looked after me well, I can't fault them one bit" and "All in all I can't fault the place."
Staff said they felt the service was safe at the time of our visits. One staff member said when asked if people were safe, "Yes we still have the staff here, so if in doubt we can ask them and someone gives us directions. The residents are safe as long as they are here."

Medicines were safely managed to ensure people received them safely and on time. People said they were happy with the management of their medicines. Comments included, "Excellent at getting those (medicines)" and "They are usually bang on time."

Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Medicine administration records (MAR) were well completed, signed in by staff and no missed signatures. Medicines were audited regularly and action taken to follow up any discrepancies or gaps in documentation. All medicines were securely stored and all stock entering and leaving the home were accounted for. The medicine's refrigerator temperature was monitored to ensure medicines were stored at manufactures recommended temperatures. However we identified that these were not recorded each day and found 18 missed entries in March 2016. The deputy manager said they would address this by speaking with staff who administer medicines. They would also add an additional check to the weekly medicine audit to include a check that the fridge had been monitored daily. The application of prescribed creams were recorded on a MAR chart with a topical cream chart in people's rooms with a body map with the area highlighted to guide staff and for them to sign when administered.

People were protected because health and falls risks for each person were identified and managed. Care records contained detailed risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people's nutritional risk, pressure damage and falls risk. People had clear skin integrity risk assessments undertaken and appropriate equipment in place to meet their needs, for example pressure relieving mattresses.

Care staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission (CQC).

The recruitment and selection processes in place ensured fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks were undertaken, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated

appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. We discussed with the provider that although all of the checks had been undertaken there was not a clear system to clearly demonstrate that all of the checks had been completed. The provider agreed and said they would look at improving the oversight of recruitment as they were actively recruiting.

A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person's needs and what to do for each person in case of an emergency evacuation of the service. This included people's mobility, sensory needs, equipment requirements, evacuation method, room numbers and identified the fire zone within the building they were in. This showed the home had plans and procedures in place to safely deal with emergencies.

The home was tidy throughout without any odours present and had a pleasant homely atmosphere. The provider employed a person to undertake maintenance issues at the home each Wednesday. Their role also included undertaking fire checks which included checking fire extinguishers, testing alternating call points and fire doors. A maintenance log book was in place for staff to record concerns. However it was not easy to identify whether actions had been taken to resolve the concerns recorded. We discussed this with the provider who agreed the system in place was not clear and said they would re design the document to make it clearer. We did not identify any issues which had not been completed. There were systems in place for external contractors to regularly service and test moving and handling equipment, fire equipment, gas, electrical testing and lift maintenance.

There was an on-going programme of refurbishment in place at the home. The provider had written a notice to people making them aware of changes. The notice included the resurfacing of the drive in the summer 2016, chimney pots had been made safe, and all the empty bedrooms had been redecorated and refurbished with new carpets and curtains. The notice went on to say that the sitting room and dining room were next for refurbishment and people would be asked their views on the colours to be used.

Risk assessments had been completed regarding the environment. These included what to do in the event of the bath hoist and mobile hoist failing, asbestos in the home, wet floors, use of the meat slicer, smoking on the premises, portable appliance malfunctions, needle stick injuries, lift breakdown, fire exit route obstructions. The risk assessments set out what could go wrong regarding these concerns, the likelihood of it happening and the action to be taken.

Staff said personal protective equipment (PPE) was available and there were ample supplies of gloves and aprons around the home.

Good

Is the service effective?

Our findings

People's needs were met by staff who had the right competencies, knowledge and qualifications. A care consultant had provided training to the care staff. This was because previously the service was registered to provide nursing care and care staff worked with registered nurses who took overall responsibility. The registered manager was trained to deliver manual handling training and also monitor staff handling skills. This ensured staff were competent and effective in assisting people to safely move and transfer if assistance was required. Mandatory staff training undertaken included: health and safety, fire, safe guarding vulnerable adults, infection control and food hygiene. Some care staff had undertaken specialist training to meet people's needs. This included: end of life care, pressure ulcer prevention, diabetes, person centred care, record keeping and equality and diversity. Staff were positive about the training they had received.

New staff had undergone an induction when they started working at the service. They had shadowed experienced staff until they and senior care staff felt they were competent to work alone. The deputy manager confirmed, "New staff do shadow shifts and are put with an experienced carer to observe and support." Staff said they felt the induction had given them the skills to carry out their roles and responsibilities effectively. The new Care Certificate which had been introduced in April 2015, as national training in best practice, was being used for new staff.

Staff said they had been supported by the registered manager and management team. Although formal regular supervisions had not been carried out over the past year. However, everyone had received a formal supervision in February 2016 which had been recorded. One staff member said "We had a real campaign but they need to be more frequent and regular." We discussed with the provider that there was no evidence that appraisals had taken place. They said they recognised the importance of annual appraisals and would put a system in place.

People's consent for day to day care and treatment was sought. 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. We checked whether the service was working within the principles of the MCA and found they were.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. 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). These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. The deputy manager confirmed that no DoLS applications had been submitted to the local authority. We did not observe any concerns that people were being deprived of their liberties at the service during our visits.

Staff had undertaken training of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and most staff demonstrated a good understanding of how these applied to their practice.

People had access to healthcare services for on-going healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, and chiropodist. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately. One person said, "District nurses come in sometimes the GP, if I ask I can see someone easily." Another person said, "When I need them (health professionals) they call them in. I got a cut on my hand, they called them and they came in and dressed it." One person had requested to see their own dentist; staff had discussed the difficulties this posed to the person regarding their mobility. They had liaised with the dentist and had taken action to resolve the person's concern. This included sending the person's dentures to be filed to improve their fitting.

A district nurse said they had no current concerns about the service. They were contacted appropriately and in a timely way. However, they had been made aware of senior care staff leaving. They confirmed they would be monitoring the service to ensure people continued to receive safe care.

People were supported with their communication needs. Care plans had been put in to place regarding people's communication and whether they required a hearing aid or glasses. In one person's care plan, staff had clearly set out the person's difficulty with verbal communication and how they made staff aware of what they wanted. This person had chosen not to use communication cards. The staff had worked with the speech and language therapist (SALT) to develop strategies to assist the person with their communication

People were supported to eat and drink enough and maintain a balanced diet. People were given the option of two meal choices. A staff member went around before each lunchtime and evening meal to ask their choices. We observed a care worker knock on the door and ask the person what they wanted for lunch. They gave them a choice of chicken casserole or Quorn casserole. People had access to drinks at all times in their rooms. Staff went around with a trolley offering refreshments to people and visitors.

People were very complimentary about the food. People's comments included, "I find it excellent, more than enough."; "Not too bad…get a choice up to a point. I could I suppose ask for an alternative."; "Good as far as I am concerned."; "The food is very good" and "The food is excellent." The provider had an external specialist develop a new four week menu in April 2015 to ensure people had a balanced diet. People had been asked their views about the food at the service in a food survey carried out in July 2015.

The cook was guided by information on a white board in the kitchen containing people's likes, dislikes, dietary requirements and allergies. Staff had gathered information about people's dietary requirements, meal sizes, likes and dislikes when they first arrived at the home. Therefore they were informed about different people's dietary needs and who required a special diet. The cook confirmed if people did not like something on the menu, they would always prepare them an alternative.

Where people had any swallowing difficulties, they had been seen and assessed by SALT. Staff had put in place a care plan guiding staff to monitor for signs of aspiration and to contact the SALT if concerned. Where the SALT had recommended soft or pureed food, each food was separately presented, which is good practice. People at risk of weight loss had their weight monitored regularly.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. People's comments included: "Wonderful, they couldn't be kinder."; "The staff are kind."; "Carers are alright."; "The staff are all very good, (registered manager) was good they are all quite cheerful and helpful."; "I have been happy here since the day I came and wouldn't want to be anywhere else. I am looked after, fed well, I wouldn't want anything else."; "Staff are pretty good." and "Care is very good here, the care being given is beyond compare." The relative we spoke to said, "I can't fault the food or care here."

Staff treated people with dignity and respect when helping them with daily living tasks. Staff said they maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering and gained consent before providing care. One staff member said, "I always ask if it is alright to give them a wash, if it is I put a towel around their lower end to cover them up. I always leave the bell when I have finished." There were notices on each bedroom door to ensure people's privacy. Staff could change the notices to indicate the room was engaged to make other staff and visitors aware the person was receiving support.

People were supported to express their views and be actively involved in decisions about their care and welfare. Staff asked people where they wanted to spend their day and what additional support they required. For example, one person had requested a bath as they had been unwell and was feeling better. People's views were continually sought by staff as part of everyday life at the home. In addition there were frequent resident meetings and quality monitoring surveys undertaken. The staff had built up strong relationships with people and discussed day to day issues as they arose.

Staff involved people in their care and supported them to make daily choices. For example, people chose where they spent their day and the clothes they wore. One staff member said, "We help them to be more independent they decide what clothes they want to wear, what they want to do we are here to assist." One person had been assessed as at high risk of developing pressure sores. Staff had discussed the need to use pressure relieving equipment with the person. They had decided they did not want to have a specialist mattress. Staff put in place a monitoring sheet to regular check the person skin.

People's rooms were personalised with their personal possessions, photographs, ornaments and furniture. People's relatives and friends were able to visit when they liked. People and relatives said they were made to feel welcome when they visited the home. Comments included, "My son can visit when he chooses" and "Visitors can come in when they chose."

People's religious beliefs were supported, and there was a regular service at the home. People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, including the person's views about resuscitation in the event of unexpected illness or collapse. We observed the staff worked closely with a visiting hospice nurse to provide end of life care to a person. They demonstrated compassion and kindness to the person receiving this care and to their family.

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. People confirmed the daily routines were flexible. They were able to make decisions about the times they got up and went to bed, how and where they spent their day and what activities they participated in.

Before people moved to the home an assessment of their needs was completed to ensure the service could meet their needs. The registered manager and senior staff would go and meet with people and their families and discuss their care needs and what was important to them. This information was then used to generate care plans to guide staff to know how to provide the care they required when they moved into the home. This ensured people's care plans were reflective of their health care needs and how they would like to receive their care, treatment and support. The care plans covered people's nutritional needs, communication, mobility, person hygiene and spirituality. There were also care plans for people's specific needs, for example, how to support someone following a stroke. When people arrived at the home staff completed and admission checklist to ensure all assessments and documents were completed. They had supported people and their families to complete the Alzheimer's society 'This is me', a booklet to help support people in an unfamiliar place. It asked people questions about what routines were important to them, things that may worry or upset them and what made them feel better if anxious or upset.

Care files included personal information about people's health and social care needs. They showed that staff had involved other health and social care professionals when necessary and identified the relevant people involved in people's care, such as their GP, optician and chiropodist. They also included information about people's history, likes and dislikes, religious and spiritual beliefs. This meant that when staff were assisting people they knew their choices, likes and dislikes and provided appropriate care and support.

Each person had a folder in their room referred to as 'bedroom folders'. These contained charts for staff to complete for example, food and fluid charts. They also contained people's mobility care plan, continence care plan, and personal hygiene care plan. These guided staff regarding people's needs. For example, how many staff the person required to mobilise and what equipment they required. The folder also contained a daily care record which was a tick sheet which staff completed each day and signed to indicate what support people had received. This included washing dressing, whether they had been offered to sit in the lounge and that their call bell was available.

Care plans were up to date and were clearly laid out. People's care plans and risk assessments were reviewed monthly by the senior care staff and more regularly if people had a change in their needs. Staff had completed consent and treatment paperwork and people had been asked if they wanted to be involved in undertaking a review when they came to the service. However, it was not clear from the monthly reviews if people had been given the opportunity. Staff said people had chosen not to take the opportunity. Nobody we spoke with could confirm they had been involved in a review, but said they were happy with the care they received.

Staff said they had read people's care plans and felt they were reflective of people's needs. This was evident

when we asked staff about the care they provided to specific people. They were able to say what they needed to do for these people which was consistently the same as what was recorded in their care plans. For example, the needs of a person who had continence issues and another who had difficulty balancing in order to have a bath.

People had previously been supported to follow their interests and take part in social activities. There had been a full time activity person employed at the service. However they had left the service and people said they had missed their input and sessions together. One person said, "We did have a person they were very good they used to do things on the big boards like a crossword." Another said "(The activity person) used to spend a lot of time with me, I miss her." A third person said, "(Activity person) was absolutely brilliant it hasn't been the same since she left."

The staff said they tried to do things with the residents but due to staff sickness this had been difficult. Comments included, "I feel there is nothing for them to do, sat in their rooms watching television and then to bed. Activities would break up the day. It all stopped when (activity person) left."; "We try to do quizzes in the afternoon but it is not always possible, try to have something for them to do, if no bells we can do puzzles."; "I feel for the residents they had a lot of input but now gone we try to go and speak but we are called away."

The provider said they had realised people had felt the loss of the activity person who was full time and had spent a lot of time with people. They confirmed they intended to recruit a new part time activity person and had already made plans to introduce additional activities. We were shown a weekly activities notice prepared by the provider to advise people about the activities at the home. These included each week a complimentary therapist; keep fit session, hairdresser and a visiting beautician. There was also a new service starting each Wednesday of arts and crafts which would also include cooking and outings. This was to be delivered by two ancillary staff members who would undertake additional duties.

People had a mixed view about whether they would join in activities. One person comments, "I don't do any that is my choice, I do some colouring on my own. I don't go downstairs." However they went on to tell us that they had visitors expected and would be meeting with them in the main lounge. Other people commented, "I join in anything that is happening, nothing recently'"; "I am quite happy with my paper, TV (television) and books. Sometimes there is a dog called Millie brought around."

We went to the dining room to observe a lunchtime meal and found that nobody was using the dining room although it was laid up. However there were two people enjoying their meal in the lounge with individual tables. One of these people said they found the dining room too small to move around and preferred the lounge. Other people said they were happy to eat in their room. One person commented, "We can use the dining room if we want to, it depends on who else is there. I prefer it on a tray in here (bedroom)." Another said, "I like lunch on my own, I don't mix well." One member of staff said, "We used to have a group come to the dining room, now a lot like to stay in their room." Another said, "They (people) like to eat in the lounge as the dining room is a bit small."

People and relatives said they had no significant concerns or complaints about the home. They said if they had any concerns, they would feel happy to raise it senior staff and it would be dealt with. However two people did not know who was in charge and who they would report concerns to. Comment included, " I would tell the deputy or a senior, I would raise it with them and they would take the necessary action."; "I would ring my bell if I had an immediate concern or speak to one of the seniors or someone at the desk.; "No I wouldn't say anything as I don't like complaining. If I had a concern I haven't the faintest idea. I would talk to me son." and "I don't know who the new manager is to complain to."

The provider had a suggestion box in the main entrance for people, visitors and staff to make suggestions, complaint and comments. A copy of the complaints procedure was in the service user's guide. This advised people who to contact if they had a concerns and advised people of outside agencies if they were not satisfied with the outcome of their complaint.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was a registered manager in post. However, their last day of employment with the provider was the final day of our visit. They have now left the service and the provider is actively recruiting another registered manager. The provider made us aware that they had received resignations from other senior staff at the home.

People and staff expressed uncertainty regarding the management team leaving and the future of the home. No one had been told what was going to happen, people were worried the home would be closing and staff morale was low. Comments included, "I am concerned so many seniors and management are leaving, I have asked what is happening. I would be happy if we had a clear guide."; "I know the residents are safe, we have been told they will get some new seniors and a manager but there is still doubt, why are they leaving" and "I hope (provider) will talk to us we need reassurance."

We received confirmation a week after our visit that the providers had met with all staff, people and relatives to give them assurances. They also confirmed they had received applications for the managers position and senior care staff. They said the senior staff that had resigned, had agreed to support the service during the transition to ensure people's safety. The deputy manager confirmed to us they would remain working at the service on a bank basis (as and when required). This was to ensure medicines continued to be managed safely and to support the provider and staff as needed. The provider also had the support of a local care consultant who delivered training, induction and support to the management team. We met with them at the inspection and they confirmed they would be working with the providers to keep the service safe during the management transition.

The provider agreed to keep the Care Quality Commission (CQC) informed on a weekly basis regarding the day to day management at the home. They said "Certainly a crisis is looming, we are determined to get a more stable staff and develop better teamwork, our overall assessment is that we are not where we want to be. We want a good calibre of staff and won't take on anybody who is not caring."

The registered manager had been supported by a part time deputy manager and senior care staff who were in day to day control at the service. The providers are at the service on a day to day basis and are available to offer support when requested. People, visitors and staff spoke positively about the registered manager and senior care staff. Staff comments included, "The care here is good the team worked well together"; "We work well as a team and I could always go to (Registered manager) if I had a problem." A visitor said, "(Senior care worker) has got the staffs respect, she is not frightened to get in there and do it herself."

Before the recent management concern people's views and suggestions had been taken into account to improve the service. The registered manager recognised the importance of this to improve the quality and safety of the service and the care being provided. For example, resident meetings took place to address any arising issues and the registered manager ensured they spent time with people on a regular basis. The registered manager had visited all of the people individually at the service to make them aware they would be leaving. People had been able to express their views at the resident's meetings. At the last resident's

meeting in March 2016 food at the service had been discussed. Following the loss of the activity person people said that care staff did not have enough time to spend with them. One person said they felt staff worked to complete tasks and that the personal time was very lacking.

The registered manager had held regular meetings with staff. These included meetings with individual teams, for example seniors and kitchen staff. At the last staff meeting in February 2016 the registered manager had been joined by ten staff. The staff were reassured regarding the needs of new people coming to the service. The registered manager said they were being more selective regarding the people they were taking at the home. To ensure they had residential needs and not borderline nursing needs. Staff were informed that a wet room was going to be installed at the home. Staff were also reminded to promote independence as much as possible and advised to have a consistent approach with people.

The provider had commissioned the care consultant to undertake a quality assurance survey of people, relatives and advocates, staff and health professionals. The surveys completed in February 2016 asked specific questions about the standard of the service and the support people received. The results of these surveys had been collated and a development plan had been implemented. This included to answer call bells more quickly, to let people who use the service know when their care plan review happened, ensure people who use the service are able to talk to their GP. These plans had been discussed with the registered manager before they left and had not been acted upon fully at the time of our visits. However the results had been shared with people and staff and a copy of the results was available in the front entrance at the home.

The provider had also commissioned the care consultant to complete an independent audit regarding the Fundamental Standards. These are the basic requirements that providers should always meet regarding safety and quality below which care should never fall. The care consultant had been working with the registered manager to implement actions identified. However this piece of work had not been totally completed at the time of our visit. The providers assured us these two action plans would be completed.

There were systems for continually monitoring the service was safe. The management team undertook monthly audits of people's care records, including how medicines had been administered and any accidents or incidents.

In October 2015 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored four with the highest rating being five. This confirmed good standards and record keeping in relation to food hygiene had been maintained. Where they had recommended actions these had been acted upon. For example, a cracked strip by the kitchen door and shelving in the fridge had been repaired and replaced.

There were accident and incident reporting systems in place at the service. The registered manager reviewed all of the incident forms regarding people falling. They looked to see if there were any patterns in regards to location or themes. Where they identified any concerns or reoccurrence they took action to find ways so further falls could be avoided. However, these checks had not been undertaken in March 2016, when the registered manager was on leave.

The registered manager was meeting their legal obligations such as submitting statutory notifications when certain events, such as when a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested and working in line with their registration.