Lifestyle Care Management Ltd

Coniston Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection was carried out on 23, 24 and 26 February 2016 and the first day was unannounced. This was the first inspection under the current registration with the Care Quality Commission.

Coniston Lodge Nursing Home provides care for a maximum of 92 people. The service has four units, three of which are for general nursing care and dementia care needs and one for people with advanced dementia care needs. At the time of the inspection there were 57 people using the service. The service is a purpose built nursing home and has been used for this purpose since it was first registered.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service has had two managers since it registered on 30 October 2015 and at the time of inspection the position was vacant and the provider was in the process of recruiting for a manager. The service was being overseen by the quality support manager until a new manager was recruited.

Information regarding people's capacity to make decisions for themselves was not always recorded. Records for people's resuscitation status needed reviewing to reflect changes in people's capacity and identify those who had been consulted regarding these decisions.

The service was 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.

Systems were in place for monitoring the service, however these were not always effective in ensuring shortfalls identified were actioned in a timely way.

People were happy with the service and confirmed they felt safe living there.

Staff provided care and support in a gentle and caring way and treated people with dignity and respect.

Risk assessments were in place to reflect the risk to individuals and the care and support they required to minimise these. Systems and equipment were being serviced to keep them in good working order.

There were suitable arrangements in place to ensure people were protected against the risks associated with the inappropriate management of medicines.

Staff understood safeguarding and whistleblowing procedures and were clear about the process to follow to report any suspicions of abuse. A complaints procedure was in place and people and relatives said they expressed concerns so they could be addressed.

Staff recruitment procedures were in place and being followed to ensure only suitable staff were employed at the service. Staff received training and updates and understood people's individual needs and choices and how to meet them.

People's nutritional needs were identified and were being met. Input from the GP and other healthcare professionals was provided to address any health concerns.

Care records reflected people's individual needs, interests and wishes and were up to date. Staff understood people's needs and provided people with person-centred care. People's religious and social needs were being identified and met.

There had been two changes of manager since the provider registered the service and the post was vacant at the time of inspection. The frequent changes of management meant people, relatives and staff were unclear as to who was managing the service and felt unsettled by this. The quality support manager was overseeing the service and with the deputy manager was providing support for staff, people and relatives.

We found breaches of one Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. The provider had arrangements in place to safeguard people against the risk of abuse.

Risk assessments were in place for identified areas of risk to minimise them.

Servicing of systems and equipment took place to maintain them in safe working order.

Staff recruitment procedures were in place and being followed. There were enough staff on duty to meet people's needs.

The provider made suitable arrangements to ensure people were protected against the risks associated with the inappropriate management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective. Staff understood people's rights to make choices about their care, however care records did not always include information relating to the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff received training to provide them with the skills and knowledge to care for people effectively.

People's nutritional needs were assessed and monitored. People's dietary needs and preferences were being identified and met.

People's healthcare needs were being monitored and they were referred to the GP and other healthcare professionals when necessary.

Is the service caring?

Good

The service was caring. Staff understood the individual care and support people needed and provided this in a gentle and caring way.

People were encouraged to make choices about their care and staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive. Care records identified people's care and treatment needs and these were being reviewed and kept up to date.

People and relatives felt able to raise any concerns they might have and systems were in place to record and investigate these.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. Systems were in place to monitor the quality of the service however these were not always effective, leading to delays in repairs being arranged and carried out.

The service did not have a manager in post and the service had experienced regular changes of manager, which was unsettling for people, relatives and staff. The quality support manager overseeing the service and the deputy manager were supportive of people, staff and relatives and recruitment was ongoing for a new manager.

Meetings had taken place with people, relatives and staff so they could express their views, with more being planned to keep them up to date with changes at the service.

Coniston Lodge 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 23, 24 and 26 February 2016 and the first day of inspection was unannounced. Before the inspection we reviewed the information we held about the service including notifications and information received from the local authority. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection team consisted of three inspectors including a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience with older people including those with dementia care needs and of care services for older people.

During the inspection we viewed a variety of records including 12 care records, some in detail and some looking at specific areas, the medicine supplies and medicines administration record charts for 20 people, four staff recruitment files, risk assessments for safe working practices, servicing and maintenance records for equipment and the premises, complaints records, audit and monitoring reports and policies and procedures. We observed the mealtime experience for people and interaction between people using the service and staff on all units.

We spoke with 16 people using the service, 12 relatives, the clinical and operations director for the provider, the quality support manager, the deputy manager, four registered nurses, 15 care staff, two activities coordinators, three domestic staff, three kitchen staff, the maintenance person and the administrator. We also spoke with three healthcare professionals, those being a GP and two opticians.

Good

Is the service safe?

Our findings

People confirmed they felt safe at the service and that they received their medicines properly.

Policies and procedures for safeguarding and whistleblowing were in place and were being followed. Staff we spoke with had received training in safeguarding and were able to provide a definition of different types of abuse when asked. All were confident that they would know how to report any safeguarding concerns and said that they would inform the unit nurse or other senior staff in the first instance. Copies of the whistleblowing procedure were displayed and accessible for staff to read. Staff confirmed they understood whistleblowing and knew who they could report concerns to, including outside agencies such as the local authority and the Care Quality Commission.

The local authority safeguarding team had been involved with the service to look into safeguarding concerns, for example, incidents of bruising or skin tears and staff knew how to report any such findings. We saw injuries were being appropriately recorded and statements taken from staff so that this information was available to feed into any investigations that took place. Body maps of injuries had been completed and photographs taken, however the progress of the injury had not always been clearly recorded. The deputy manager said this would be addressed. Monthly audits for accidents and incidents including skin tears were carried out to ensure any injuries were being identified and monitored.

The provider held monies on behalf of people using the service and we viewed a sample of records. All income and expenditure was clearly recorded and invoices were available for all expenditure. This showed monies held were being safely managed for people.

Risks were being assessed so action could be taken to keep people safe. Risk assessments had been undertaken for individuals and recorded in each person's care record. These included assessments for the risk of malnutrition, risk of developing pressure sores and falls risk. We saw risk assessments in the care files for individuals. Risk scores were updated monthly and where a risk had been identified the care plan addressed the risk with measures to minimise or manage the risk. Risk assessments for premises, equipment and safe working practices were in place and had been reviewed by the quality support manager in November 2015, to keep the information current.

Servicing and maintenance records had been completed and we saw systems and equipment including gas appliances, hoists, fire safety equipment and lifts were being serviced at required intervals. The fire risk assessment had last been completed in October 2014 and we saw a date for this had been arranged for March 2016 to review fire safety for the service. Personal evacuation plans for fire safety were seen on the units and identified the method of evacuation for each person, so this was available to those involved in an evacuation of the premises. There was a business continuity management plan in place dated December 2015 and this included the action to be taken in emergency situations, including nearby services where people could be evacuated to in the event of an emergency.

Employment checks were carried out to ensure only suitable staff were employed at the service. Completed

application forms included employment history information and gaps in employment had been discussed at interview and the reasons for these identified and recorded. Pre-employment checks including a Disclosure and Barring Service (DBS) check, references from previous employers, proof of identity and evidence of people's right to work in the UK had been carried out and medical questionnaires had been completed. Two files viewed did not contain a recent photograph, however we saw copies of identification documents that included a clear photograph. The quality support manager said she would ensure photographs were taken and included on the recruitment files. The service was using agency care staff and registered nurses and we saw that recruitment information had been supplied for these staff by the two agencies used, to evidence that the required checks had been carried out.

We observed that there were enough staff on duty to attend to people's needs, and staff were on hand to assist people with personal care, to move around the service and to get to their rooms as required. Staff commented that there were usually enough staff on duty but said that when care staff were absent unexpectedly they were sometimes short staffed. Some staff reported that there was less use of agency staff now and felt the increase of permanent care staff levels had improved the effectiveness of teamwork. A recruitment drive was taking place and interviews took place during the inspection. The quality support manager said there were ten new care staff for whom pre-employment checks were being carried out and more staff were being recruited. Relatives reported that there were usually enough staff to assist people and said that their relatives were well attended to in a timely fashion. Call bells were answered promptly during our visit and we saw that call bells were in reach of those who were in bed.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the supplying pharmacy and the provider, including safe storage of medicines, room and fridge temperatures and stock quantities on a daily basis. When asked, the deputy manager stated that no medicines incidents or near misses had been reported recently. However, they demonstrated the correct process verbally of what to do should an incident or near miss arise in the future, including who to contact. This was in line with the provider's policy.

People received their medicines as prescribed, including controlled drugs. We looked at 20 Medicines Administration Records (MAR) and found no discrepancies in the recording of medicines administered. Furthermore, all remaining stock quantities that were recorded on the MAR reconciled exactly to those contained in the respective blister packs. This was confirmed with one person who reported that they received their medicines in a timely and correct manner. Medicines were stored and locked away appropriately in the treatment rooms. The medicines for disposal were placed in the appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Room and fridge temperatures were audited on a daily basis and were in-range, and controlled drugs were appropriately stored in accordance with legal requirements, with twice daily audits of quantities done by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them, even though there were some discrepancies in the documenting of these protocols. For example, we saw that one person's laxative had been changed but the protocol had not been updated to reflect this. When brought to the attention of the deputy manager, this issue was resolved before the end of the inspection. People's behaviours were not controlled by excessive or inappropriate use of medicines. For example, we saw 12 PRN forms for pain-relief or laxative medicines. There were appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine did not have its intended benefit.

We found that people received their medicines in line with the Mental Capacity Act 2005. We observed four

people's MARs whose medicines were administered covertly. We found that all of them had an individualised protocol and the appropriate authorisation from the GP and pharmacist were sought and documented on a 'Covert Medication Form'. This included the practicalities of administration, information on the crushing of tablets and how often it was to be reviewed. Also, we saw evidence of a mental capacity assessment and best interests meeting for each person in their care plan.

The deputy manager confirmed they were happy with the arrangements for medicines in place with the supplying community pharmacy and GP, and felt that the provider received appropriate support with regards to the training of nursing staff of high risk medicines (such as warfarin) and medicines reviews. This was evidenced by checking the record of a medicines review that had been carried out within the last six months. The deputy manager confirmed that at least one GP from the same surgery visited every week to review people using the service.

Policies and procedures for infection control were in place and being followed. The service was clean and fresh and any issues with cleanliness were being attended to promptly. Cleaning schedules were followed and records were completed to evidence the cleaning being carried out. Staff told us they received regular updates on infection control and were able to explain the procedures they followed to keep the service clean. Bedrooms had en suite toilets and hand basins and those viewed were all clean as were the toilet and bathroom facilities we viewed. Staff wore personal protective equipment (PPE) that included aprons and gloves when they were assisting people with personal care. We did not see PPE being used excessively and used items were disposed of in designated clinical waste bins. Treatment plans were in place to manage a bed bug problem and staff understood the procedure to follow to report any sightings so action could be taken promptly to address the situation. We spoke with domestic and laundry staff about infection control in relation to managing the bed bug issue and all were clear about the action they were to take to prioritise areas of work to address the situation.

Requires Improvement

Is the service effective?

Our findings

Some care files contained completed 'do not attempt resuscitation' (DNAR) forms. We saw that with one exception where a hospital doctor had signed, these had been signed by the person's GP, however sections for recording that discussion with the person and/or their next of kin had taken place and the reason for the DNAR order had not always been completed. We also saw that in one case the form stated a person did not have capacity whereas the person had since been assessed as having capacity, so this needed to be reviewed and updated accordingly. The care files also contained a section in the personal care and physical wellbeing care plan which gave an indication of people's wishes with regard to death and dying and only two of these care plans reflected the DNAR decision.

Apart from the assessments relating to the use of covert medicines, information on whether a person had capacity to make decisions was limited, with only one other completed mental capacity assessment form seen in the care records we viewed. Care plans for mental health/cognition were in place, however they did not address people's capacity.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff all confirmed that they had regular training so that their skills and competencies were kept up to date. Staff considered that the amount of training provided was adequate and explained that with the new provider, training took place using online training modules and they had to gain 100% in order to pass each module. Staff were able to give us examples of recent training they had undertaken such as health and safety, safeguarding and food hygiene. Newer care staff outlined the induction process for new employees, including mandatory training, corporate induction and a period of shadowing and supervision to help them to learn how to care for people effectively. Staff were able to clearly outline individual people's needs and were familiar with the people's different routines, preferences and any behavioural patterns, for example, wandering during the day or night time waking. The quality support manager confirmed that ten care staff had recognised qualifications in health and social care and three were commencing the training. The Care Certificate induction was being introduced in March 2016 for new staff and those who had not completed a recognised training course in health and social care.

Staff confirmed they received one to one meetings with their line manager and could discuss their training and development needs. Some staff reported this occurred every two months while others said that they had not had supervision for over a year. Staff had not received annual appraisals in the last 12 months. The issue with supervision and appraisals had been identified by the provider and a new supervision and appraisal programme had been devised. The quality support manager had completed a supervision diary to ensure all staff received regular supervision in the future and we saw this had been commenced in January 2016 and was being progressed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff understood people's right to make decisions for themselves and we heard staff offering people choices, such as where they wanted to be and what they wanted to eat or drink. We saw staff spoke with people to find out their wishes and worked with people to provide the care and support they wanted. The care files contained a consent form that covered a variety of areas for people or, where they were unable to do so, someone with the authority to act on their behalf, to sign to give their consent. This included consents to photographs and for others to access care documentation and although it mentioned care and treatment the document did not clearly record that people were consenting to receive care and treatment. We discussed this with the quality support manager who said they would feed back to the provider around this point to ensure this was clearly recorded. The quality support manager had completed DoLS applications for the majority of people living at the service and at the time of inspection these had been authorised for ten people. There was evidence in the care records that assessments had been undertaken by healthcare professionals with regard to the DoLS applications and the outcomes were being awaited.

The quality support manager was clear about the processes that needed to be followed to ensure that where someone did not have capacity to make decisions for themselves, someone appropriate was appointed to make decisions on their behalf. The quality support manager said that many of the people using the service who did not have the capacity to make their own decisions also did not have anyone who had the legal right to make decisions on their behalf, for example, someone with lasting power of attorney for finances and health and welfare. They were clear that, where necessary, applications to the Court of Protection for an appropriate person to be appointed as a Deputy to make decisions on behalf of a person would have to be made. The service had recently had CCTV installed and this was another area where work was being undertaken to discuss and seek permission for use of CCTV in bedrooms from each person or, where they did not have capacity to give permission, from someone with the authority to act on their behalf.

We asked people what they thought about the food provision at the service. Comments included, "The food is good" "I'm lucky, I get given my food and I eat it." "I eat what I'm given and hope for the best." "The food is alright, I've eaten everything they've given me" and "It's lovely food here. Nice, good food." One person said, "I don't like the potato; it's sloshy, so I ask them to take it away." We observed the mashed potato was very liquid on the first day of our inspection, whereas on the other days of our inspection it was of normal consistency. The catering staff explained this was sometimes due to the type of potatoes they had been supplied with and agreed this needed to be monitored to ensure it was always appetising to people and met their preferences.

People's nutritional needs were being identified and met. People's nutritional status was assessed and each person had a care plan that identified their dietary needs. This included their preferences, likes/dislikes, the support they required with eating and any allergies. Any specific dietary requirements were recorded, for example, the need for soft or pureed food, any eating difficulties, assistance people required with eating and any dietary needs for religious or cultural reasons. People were weighed each month and this was recorded and the records were up to date. Care plans evidenced appropriate action such as weekly weight monitoring or referral to dieticians where appropriate, for example if someone had lost weight. Food and fluid intake was also monitored for people identified as being at nutritional risk and records viewed were up to date.

There was a four week menu and the content was balanced and nutritious. People could have a cooked

breakfast and several people commented that they enjoyed this. In addition to mealtimes, we saw hot drinks were served in the morning and afternoon and water and other drinks were readily available throughout the day in communal areas and in people's rooms, so they were easily accessible. Staff were available to assist people at mealtimes so they received the care and support they needed. Staff understood the different support each person needed and worked hard to ensure people received their meals to maintain a good dietary intake.

People confirmed they received input from healthcare professionals. One person had recently been seen by the dentist and provided with a denture, which they were very satisfied with. Visits from health care professionals were recorded in the care records. Forms recorded the date, the name of the healthcare professional, the reason for the visit and the outcome. GP visits had been well documented and there was evidence of visits from other healthcare professionals such as the dietician, tissue viability nurse, speech and language therapist, optician, dentist and chiropodist. Healthcare professionals told us people were referred to them appropriately. One was very positive about the help and support they received to ensure they were able to see people and provide the healthcare input they required. During the inspection a person received input from a physiotherapist. The registered nurse said she would complete a care plan to reflect the instructions they had received, so staff would know the exercises to carry out with the person to assist with the physiotherapy programme.

Good

Is the service caring?

Our findings

We asked people if they were happy with the care they received. One person told us, "They know how to look after me" and when we asked in what way they said, "Well, they seem to satisfy me all the time." Other comments included, "They are looking after me very well" and "They're lovely here. This one [staff] is a sweetheart. I don't know what I'd do without them." One person did not say very much, but they responded with lots of smiles and nods to our questions and indicated they were happy at the service. Another person was difficult to understand but smiled and was enthusiastic in their responses to us, which included, "They're nice people, they help."

Relatives were mostly positive about the care received and said the staff working at the service provided good care, looked after their relatives well and were familiar with their needs. They said they always felt welcome at the service and that turnover of the permanent staff was fairly low, which meant that they were familiar to people which they felt was reassuring. Comments from relatives included, "The staff are fantastic – very committed and we always feel welcome when we come in" "We're very happy with the care here. The staff are familiar and communicate well" "Yes, they are looking after [relative] well" and "I've been very happy with the care here. I think the people do a good job – it's not an easy one. It would be great if these people who work as carers could be given better status."

We received feedback from three relatives that there were occasions when communication with people was limited and one relative said, "The staff are very attentive to their physical needs but they don't really ever chat to residents." We observed that while the majority of staff communicated well with people and received positive responses, there were occasions when communication was limited between staff and people, for example, a member of staff not explaining when providing a cushion for someone's arm to rest on. The provider had already identified the need for social interaction between staff and people to improve and a compliance officer for the provider visited on the first day of inspection to review lunchtime practices, to monitor and provide feedback to the management. The quality support manager was very clear about the importance of communication and of working with staff to improve this.

Care plans were personalised and recorded people's individual preferences and routines, with details on any cultural or religious requirements if relevant. Staff demonstrated they were aware of people's different needs, abilities, preferences and personalities and took time to acknowledge and accommodate these. We saw people were able to get up when they were ready and staff were clear that if, for example, someone wanted a lie-in, this was respected. Some people were engaged in activities in the lounges and others were able to sit in other communal areas or remain in their rooms, depending on their wishes. We observed that people were assisted to eat appropriately and staff gave people time and offered them alternative choices if they changed their mind about what they wanted or if they refused food. We saw people were provided with meals to meet religious and cultural needs and catering staff were clear to ensure these needs were met. Each month church services were carried out by the Church of England and the Vineyard Church and a representative from the Roman Catholic Church regularly visited the service.

Staff were gentle and cheerful and were unhurried when providing care and support to people. We saw that

when staff spent time chatting, people responded positively and it was clear this positive interaction was enjoyed by people and staff. We observed people's privacy and dignity was respected and staff ensured bedroom and bathroom doors were closed when delivering personal care. Staff always knocked on bedroom doors before entering. We asked staff about people's preferences with regard to personal care and they were clear people had the right to choose the gender of the staff to provide this care and knew people's wishes. People looked cared for and were well dressed. Bedrooms were personalised with people's possessions and some rooms had the person's photograph and name on the door, to help familiarise them with where their room was.

Good

Is the service responsive?

Our findings

People had been assessed prior to moving to the service to identify their needs and ensure the service would be able to meet these. Pre-admission assessment documents viewed were comprehensive and provided a good picture of the person and their needs. Care records had recently been transferred to use the care documentation for the new provider. These were well ordered and indexed and made it easy to access risks assessments and the matching care plan. Care records contained background information about the person, a recent photograph and an overview of key details including contact numbers for GP, other relevant health care professionals and next of kin and any known allergies.

Care plans were person-centred and identified the care and support each person required. There was clear documentation on the practical and clinical care and support required from staff to meet people's needs for each aspect of care. We saw where people's conditions had changed the information had been updated to reflect this. The care plans and risk assessments had been reviewed and updated each month to keep the information current. Some care plans had additional documentation if specific monitoring was required, such as behaviour diaries or observation charts, which were being completed to record people's behaviour patterns, so this was monitored and feedback could be provided to the GP and other professionals. Daily records were completed by nurses to provide regular updates on clinical aspects of care to supplement the daily diary notes which were completed by the care staff. There was a handover file on each unit, with a section for each person. This was completed for each shift and was up to date, identifying any current issues. There was also a communication diary on each unit which recorded issues of note such as reminders of health or social care visits or appointments and any areas of concern. These records were well maintained and were up to date.

Staff said they sometimes read the care plans but mainly relied on information from nurses, handover communication and other experienced staff to learn about people's different care needs. Staff were familiar with people's needs and routines and could correctly relate any particular requirements or risks to us, demonstrating an understanding of people's individual needs and how to meet them. Agency staff confirmed they worked alongside experienced staff to learn about people's individual needs. The service was introducing a one page 'snap shot' care plan to provide all staff caring for people with a simple picture of each person's needs that was easy to read and identified the care and support someone required on a day to day basis. We saw an example and this was clear and easy to follow.

People with wounds were receiving the care and treatment they required. Wound care records were in place for people with wounds, for example, a pressure sore. We looked at wound care records for two people. Both were well maintained with evidence of input from the tissue viability nurse and a copy of the wound care plan with details of dressings and frequency of dressing changes. Records of dressing changes and wound review assessments were up to date along with regular photographic evidence of wound progress, which evidenced wounds were improving. We saw pressure relieving equipment was in place and being used in conjunction with repositioning people in order to maintain people's skin in good condition.

We saw where one person had been involved in their care record and the deputy manager said where

people were able to provide input, this was being progressed. Relatives said they had not been involved in a formal review of people's care and treatment but commented that the staff were good at keeping them up to date and informed about their relative's progress or any concerns. One told us, "They always keep us up to date – if there's an infection or if she's unwell." Another said their family member had a history of falls and the service had taken action to identify and provide equipment to help minimise the risk of falls and injury, thus responding to this need. One person told us how since coming to live at the service their ability to mobilise around had improved and was continuing to progress, which had been due to the help and support they had received.

We asked people about activities at the service. Comments included, "We have lots of entertainment here. We have singing every week [which] sometimes gets so crowded there's no more room." "I don't get bored – I like watching TV." Each care file had a 'Life Story' booklet which had mainly been completed by the person or a family member to provide information on the person's background, employment history, family, hobbies and other relevant details to provide staff with background information about each person. There were two activities coordinators, one full time and one working two mornings a week. There was a weekly activities schedule which was displayed prominently and there was a range of suitable group activities each day. We observed a sing song and a bingo session during the inspection and on one of the evenings a musical entertainment was provided. There were outside entertainers and volunteers who came to the service to supplement in house activities and the plan included activities for every day. The activities coordinator maintained a separate file to record participation in activities each day for each person, so they knew how people had responded to each activity. The activities staff said they visited those people who remained in their rooms to chat with them/take them newspapers to avoid isolation.

The service had a complaints procedure and this was displayed in the reception area during our inspection. We viewed the complaints file and saw that complaints received had been recorded, investigated and responded to. Where complaints related to people's care needs we saw that care records had been reviewed to check they contained information to address any points raised in complaints, such as the use of sensory aids and people's food preferences. People and relatives felt able to raise issues and said they would seek out a permanent member of staff, either a registered nurse or the deputy manager to speak with. It was acknowledged that with the recent changes in the management of the service not all people and relatives had a clear picture of who was managing the service and the quality support manager said this would be addressed.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not being monitored effectively.

We received feedback from staff regarding shortages of equipment including crockery, cutlery, linens and wheelchairs. We spoke with the quality support manager who confirmed new linens and towels had already been ordered and following the inspection an order for additional crockery and cutlery was placed and evidence of this sent to CQC. They also told us that a tour of the service following the inspection had identified additional wheelchairs which had been checked and those in good order had been put back into use. During the inspection we were told one hoist had been loaned to a nearby service while they awaited delivery of a new one. Staff had been able to use equipment from another unit but this was time consuming and could lead to delays in attending to people. The hoist was retrieved at the time of inspection as it was ascertained the new hoist had been delivered sometime previously to the other service, but the loaned hoist had not been returned and this had not been followed up.

The maintenance person carried out monitoring for health and safety and there was a comprehensive booklet containing all the checks that were done. We saw there had been some delays to repairs being carried out, for example, identifying nine exterior lights were not working for a period of five weeks and no action had been recorded to address this. We saw a list of repairs that had been reported to the provider and some had not been actioned. We spoke with the quality support manager and the clinical and operations director who followed this up at the time of inspection. They discovered some items had been actioned but others had not been reported correctly to the maintenance department so had not been addressed. Action needed to be taken to ensure all aspects of the service were monitored and action taken to address any shortfalls identified in a timely way.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Other aspects of the service were being monitored and action was taken to address any shortfalls identified. The deputy manager carried out care records audits and we saw these were comprehensive and identified each shortfall, which were then addressed by the nursing staff. Monitoring of other records including falls, weight, wounds and skin tears was carried out monthly and action taken to address any concerns was recorded. A comprehensive quality monitoring visit had been carried out on behalf of the provider on 26 January 2016, covering most aspects of the service. The report from this was comprehensive and had an action plan for the shortfalls identified. The quality support manager had reviewed the action plan and included dates for completion for each area of work. She said that there had also been a full environmental audit of the service carried out shortly before the inspection and once the report for this was received the development plan for the service would be completed, to cover all aspects of improvements that were required, with timescales for action.

We received feedback from relatives that they were concerned about the lack of continuity of management for the service. Comments from relatives included, "The staff are wonderful but the management are weak.

There's no nurturing of staff and no sensitivity to their needs. They have little support and I think they're undervalued" and "I feel very sorry for staff. They do their best and some are really wonderful but they're really stretched." Staff did not feel the changes in management had been communicated to them effectively. Comments from staff included, "The management keeps changing – we don't know if the manager has left or who is in charge" and "There have been three managers in the last year and no-one knows who is around or who is in charge now. Staff are very unsettled." It was clear in our conversations with staff that they enjoyed working at the service, however they were unsettled by the changes of management and needed some continuity.

The service had been registered with the current provider since 30 October 2015. There had been four changes of manager in the past 12 months and the most recent had only been in post for a few weeks before leaving the week prior to the inspection. The previous manager had been registered with CQC and applied to cancel their registration during the course of this inspection. The deputy manager had been in post for several years and feedback from people, relatives and staff demonstrated they were supportive and provided continuity at the service. The quality support manager was overseeing the service at the time of inspection. They were knowledgeable about the service and were managing it and working hard to provide some stability and identify areas for improvement within the service. Staff said they found them approachable and supportive. We fed back the concerns regarding lack of knowledge about who was managing the service and the quality support manager said this would be made clear to staff at the meeting on 25 February 2016. On the last day of inspection she confirmed staff had been told she was overseeing the service while a new manager was being recruited.

The service had recently installed CCTV within the building but this was not yet in use at the time of inspection. The quality support manager told us that permission from people and, where people were unable to make decisions for themselves, the person with appropriate authority to make decisions on their behalf, had to be in place prior to this being used in bedrooms. Notices were put up during the inspection to identify the use of CCTV so anyone in the building would be alerted to this. Some care staff were anxious about the use of CCTV in the service and said that they had not been properly informed about the provider's plans. We asked the quality support manager and clinical and operations director about this. They informed us staff had been written to in December 2015 about the installation of CCTV. We saw a copy of the letter, which explained about the planned installation of CCTV and provided references to further reading regarding the use of CCTV. Work was needed to ensure all staff had read and understood the information and the quality support manager said this would be followed up with staff.

Although relatives were complimentary about nursing and care staff, they were unaware of the current management arrangements and said they did not see the manager. This was of limited concern to most as they said they always referred to senior nursing staff or the deputy manager, who they considered were accessible and responsive. Several commented that they had not been kept informed about recent management changes and had not been sent agendas in advance of the residents and relatives meetings. This meant that some had been unaware of the topics for discussion, for example, that CCTV was discussed at the last meeting, so they missed the opportunity to contribute. The quality support manager said action would be taken to inform people and relatives about the current management arrangements for the service.

Meetings for people, relatives and staff had taken place in December 2015 and a staff meeting also took place on 25 February 2015. The new provider's customer services policy and procedure included meetings for people and relatives twice a year and customer satisfaction surveys every six months. Surveys were scheduled to be sent out in April 2016 and people and relatives could speak with the quality support manager and the deputy manager to raise any points between meetings and surveys. There were daily flash meetings for the heads of department to identify any issues that needed attention. There were daily

handover meetings on each unit to discuss people or concerns and ensure staff were informed about any changes. Staff knowledge showed the meetings were effective at ensuring information was passed between staff.

The quality support manager told us she attended local authority training sessions, for example, for safeguarding adults, to keep up to date. She also attended the provider's registered managers meetings and was involved in any areas identified for work such as DoLS and studied relevant guidance to provide her with the knowledge to be able to provide support to managers on this topic.

Policies and procedures covering all aspects of the service and people's care were in place for November 2014 and we saw where some had been reviewed, for example, a policy for entral feeding dated September 2015. The clinical and operations director confirmed the updated documents from December 2015 were made available to the service following the inspection.

Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always: 1. Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. 2. Maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17(2)(a)(c)