Bupa Care Homes (CFHCare) Limited

Crawfords Walk Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 2 and 3 March 2015 and was unannounced on the first day. We last inspected this location on the 8 October 2013 and found that they were meeting the regulations.

Crawfords Walk nursing home comprises of four purpose-built units in the Hoole area of Chester. The service is owned and operated by BUPA care homes. Northgate is a unit for people with enduring mental health illness issues, Watergate and Eastgate are units for people living with dementia and Bridgegate unit provides care for those with physical health needs. At the time of our inspection, the service also was providing "hospital at home" to those requiring short term care in order to avoid the need for hospital admission. This was overseen by the clinical commissioning group.

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

Summary of findings

service is run. He was supported by two clinical nurse leads. In addition there were unit managers and deputy unit managers with responsibility for each of the four separate units. Each unit has its own dedicated staff team.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on 1 April 2015. You can see what action we told the provider to take at the back of the full version of this report

People who spoke with us said they felt safe living at the location and that the staff were kind to them. We also had positive feedback from relatives that we spoke with that visited on a regular basis. However, we found that some improvements were required in order to make the environment safer and better suited to meet the needs of some of the people living E.g. the provision of an outside smoking area, better room signage and remedial repairs.

We saw that there were good relationships between staff and the people they looked after. However, we found that staff did not always understand the needs of the people they looked after or provided the care needed. For example, some staff on one unit ignored people who were distressed or trying to attract their attention as they saw the behaviour as part of the persons illness. People had a care plan in place to enable staff to record the care required but we found that this was not always a true or accurate reflection of the care that someone needed or received.

People needed medicines to keep them well and we saw that the provider had processes in place to ensure that medicines were ordered and stored safety. There were some good practices from staff that ensured people received what they required. However we had concerns about the use of "Thick and Easy" as staff had not used the product in accordance with the prescribers' instructions so fluids were not thick enough. This could place people at risk of choking. Thick and Easy is designed to easily thicken foods and fluids for people who have difficulty swallowing. We brought this to the attention of the registered manager.

We saw that staff involved people and their relatives in decisions about their care and treatment. The provider had ensured that, where someone lacked capacity that decisions were made in someone's "best interest" and in line with the principles of the Mental Capacity Act (MCA). They had also made a number of applications to the supervisory body under the Deprivation of Liberty Safeguards (DoLS) where they felt they were placing restrictions upon someone e.g. restricting them from going out or providing one to one care.

People received care from staff that were suitable to care for them and the provider had followed safe recruitment processes. Staff also received training relevant to their job role. There were a number of meetings held with staff that provided them with support and the opportunity to discuss concerns.

The provider had taken steps to report safeguarding incidents and complaints to the relevant authorities and we saw that actions had been taken to remedy concerns. People we spoke with and relatives knew how to raise concerns and were confident that they would be listened to.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not completely safe.

People that we spoke to and their relatives told us that they were safe and cared for. The provider had developed and trained staff to understand and use appropriate policies and procedures in regards to safeguarding.

Staff providing care had been through recruitment, section and training that ensured that they were appropriately skilled to carry out their job roles.

However, although the provider had systems in place to ensure the safe management of medicines but we saw that people did not always get medication as it was prescribed to them and this could put them at risk.

We also found environmental hazards that could cause harm to people. The provider had already identified some of these and was seeking remedial action.

Is the service effective?

Requires improvement 

The service was not fully effective.

The service followed the principles of the Mental Capacity Act and made sure that the rights of people who may lack mental capacity to make particular decisions were protected. Applications had been made under Deprivation of Liberty Safeguards (DoLS) by the provider to ensure that any restrictions placed upon people were assessed.

Staff received training and felt supported in their roles.

People had mixed views about the choice and quality of the food but we saw that people received support with eating and drinking.

People living with dementia were living in an environment that needed some improvement in order to help them achieve more independence.

Is the service caring?

Requires improvement 

The service was not always caring.

We saw that most staff showed compassion and had an understanding of the needs of those that they cared for. However, this was not consistent across all units and we saw that some people were ignored or left unsupervised for long periods of time.

The provider made information available to people and relatives about the service and what could be expected from the service.

Is the service responsive?

Inadequate 

The service was not always responsive.

Summary of findings

We saw that care plans indicated people personal choices and preferences in terms of their care. However, we saw that staff did not always take this into account. We also saw on one unit that staff recorded that care had been delivered when it had not.

Activities were on offer but this was not consistent across the whole of the home.

People and relatives knew how to make a complaint and there was evidence that the provider had taken appropriate action where there had been concerns.

Is the service well-led?

Requires improvement 

The service was not well led.

People and relatives felt that the registered manager was approachable and that he spent time on the units taking to them.

Staff felt supported and there were ample opportunities for staff to meet and discuss issues of concern with the registered manager and the management team.

The provider had systems and processes in places to assess the quality and effectiveness of the service and had already identified areas of improvement from their own action plan. However, we found that these were not robust enough to identify poor practice

The unit managers were not consistent in their leadership across the home and so there was a variation of quality of care.

Crawfords Walk Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 3 March 2015 and the first day was unannounced.

On each day there were three adult social care inspectors and they were accompanied by an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we analysed and reviewed all information that we held on the provider such as notifications of key events. We also looked at the information that they had submitted to us in the provider information return. Before 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 spoke to 11 people who used the service, 12 relatives and nine members of staff. We looked at the care records of nine people and this involved looking at all of their care notes, and speaking to them and their relatives where we were able. We also carried out general observations on all four units and used the Short Observational Framework for Inspection (SOFI) on Watergate and Eastgate. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke to the management team and looked at the records that are kept about the general management and organisation of the service. These included staff files, rotas, maintenance logs, quality audits.

We spoke to other professionals that visit or commission beds from the service. These included the local authority safeguarding and quality team who had no concerns. We also spoke with the Infection Control Team who felt that the home followed instructions and advise appropriately.

Requires improvement

Is the service safe?

Our findings

The people that we spoke with told us that they "Felt safe" and that "Staff loved and took care of them". Relatives that we spoke to shared this view. "I don't worry about [my relative] anymore or their care because I know they are safe, "I think the care is wonderful". The staff that we spoke with had received training in safeguarding adults. They were able to tell us what they considered abuse or poor practice was and were clear on how they would report this. The provider had a safeguarding policy in place and the staff were aware of this. We saw that the registered manager reported safeguarding incidents and lower level concerns to the local authority and where appropriate to the Care Quality Commission (CQC). There had been appropriate reporting and actions taken.

We saw that the provider had systems for managing medicines. We saw that staff administering from the medication trolley gave the right medicine to the right person and assisted them to take this as per instructions, for example with food or fluids. We heard one staff member say "Sorry to interrupt your breakfast but can you please take your medication before you finish as you need to take it with food". We observed staff administering medication in a person centred way. We saw that staff ensured that a person had their medication early in the round as they said "[x] gets anxious if they wait so I always give it to them as soon as they see me". We also saw a nurse take a person's pulse before administering a particular medication as it should not be given if the heart rate was low. They also gently roused a person dozing and to explain to them that they needed to take medication. They were patient and discreetly encouraged them to swallow their medication. Where people took an "as required" medication, there was a care plan in place to direct staff as to in what circumstances it should be given. People confirmed that they had these when required. A person told us "I have my painkillers given to me by a carer and I am really trying to manage without them but if I think I need them I just go and ask". Staff were also aware, and recorded, factors that may affect someone's consent to medication e.g. "[b] gets upset when tablets are different colours and shapes to what they are used to".

However, we were concerned that on two of the unit's support staff did not recognise that "thick and easy" was a prescribed agent and it had to be used safely and correctly. We saw that six people were not given drinks made to the correct consistency as they were made with "two scoops per 200 mls" where they were prescribed "1.5 scoops per 100 mls." Not all of the tubs had dispensing labels and we saw that stock for one person had run out and staff were using that prescribed for someone else. This meant that people were not getting their fluids at the right consistency and there was a risk they could choke. The amount of thickener required by each person will vary and is dependent on how much fluid they drink and which consistency is required. We recommend that the provider follow the correct guidance in the administration of medicines such a NICE Managing medicines in Care Homes March 2014.

We noted that on three of the four units that there was a strong smell of urine at various times of the day. Staff told us that some of the carpets needed to be replaced they had been soaked with urine in the past and the smell could not be removed with deep cleaning. We found that, particularly on Watergate, areas and rooms in a poor state of repair for example wardrobe and cupboard doors were loose and in two bedroom's cupboard doors had come off and were propped up against walls and radiators. There were a number of chairs and wheelchairs in the corridor blocking doorways including that of the toilet. This meant that there was a safety risk to those people using the rooms. We saw that a person had the curtain tucked onto the rail and we were told by a visitor that "They pulled it down a few weeks ago and the maintenance man had not been around to put it right as they have been on holidays".

We saw across the units that many of the seats were old and fabric was ripped. This was an infection control risk as it meant that they could not be kept clean. On Watergate, we noted that nine people only had commode chairs in their rooms and these were not suitable for general sitting. We brought this to the attention of the unit manager provider who told us that they would immediately review the use of these.

The registered person failed to ensure that people were protected from the risks associated with unsafe premises. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service safe?

Accidents and incidents were reported by staff and a copy of the form kept on file. The registered manager checked the information for any gaps. Incidents were included on a monthly return to the provider so that an analysis could be carried out. We saw that where individual risks had been identified, actions had been taken. During one of the "11 and 11" staff meetings, we observed a discussion around the trial of movement sensors as opposed to pressure sensor mats. We saw that risk assessments were in place, where concerns had been identified to a person's health and welling, and that these were reviewed on a monthly basis.

People that we spoke to told us that they did not have to "Wait for help" and that they felt there were enough staff on duty although "They have to prioritise as there is so much to do". On the days of our inspection we observed sufficient staff to meet the needs of people being cared for. All the staff that we spoke to told us that staffing levels were "Adequate" but did not allow "Time to spend with people to provide emotional and psychological support." "Sometimes I feel that they deserve a little extra time". Staff told us that shifts were well organised and that they tried to use bank staff rather than agency to cover gaps. People we spoke with and relatives told us that they were "Impressed with the consistency of carers".

There were a number of small lounges not used during our visit, and staff told us this was because they did not have enough staff to supervise these spaces. We spoke to the registered manager as we observed on Watergate that people were left unsupervised in the main lounge for long periods of time. We observed one person was unsteady on their feet and tried to walk away from their chair and another walked about with their shoes not properly on their feet. We had to bring this to the attention of staff, as they were sat a corner of the room, writing daily notes, where they were not able to directly observe people. It was noted also that the "provider monthly review" in February 2015 referred to Watergate as "Having a higher than usual incidents of falls" but there had been no analysis to date of the cause. We discussed this with the provider as; from our observations the lack of supervision provided to people on Watergate unit and deployment of staff was a concern.

The provider had systems in place to ensure they recruited staff that were suitable to work within the service. We looked at nine recruitment files and saw that the required checks with the disclosure and barring service had been carried out as well as there being evidence of suitable references on file. The provider had checked qualifications where these were a requirement for the job.

We saw that health and safety checks were carried out in regards to the safety of the premises such as gas safety, electrical testing, fire risk assessments, environment health checks, and safety of equipment. The provider had an emergency plan in place and an easy to read copy of this was placed at the entrance to each unit. This included personal evacuation plans for each person in the event of a fire or other emergency.

Requires improvement

Is the service effective?

Our findings

People we spoke with and relatives had mixed views about the food. They told us; “I have some complaints about it from time to time, mainly about the temperature and choice”, "I don't think the food is of a good standard, and it's a shame, because it's often the last thing that people enjoy", “I like the food here, it’s very good it's more like a little hotel”, “I am a picky eater but they always find me something”.

The menu was set out by BUPA in four weekly cycles across all of its establishments and food was cooked from fresh. There was a choice of options each day but it was not “Always what people might choose for themselves.” The kitchen staff told us that they had a small budget in order to purchase foods not on the menu and we saw that they made alternatives such as a jacket potatoes. We saw that the chef piped pureed food onto plates in order to make it look more attractive. There was a menu displayed on the wall and this showed the options for the day. Staff also had a picture version of the meals that assisted people to make a choice if necessary. A selection of plates and cups were adapted so that people could eat and drink independently. People told us that whilst they could have drinks in the day, there was not always the opportunity to have snacks. We observed one person asking for an afternoon snack and this was not dealt with.

We saw that staff were mostly attentive to people's needs and offered choice throughout the meal. We also saw where one person did not want anything, a staff member tried several suggestions before the person agreed to have a sandwich. Staff chatted with people explaining what they were eating and trying to encourage people to take a little more. We also saw that family members provided support at mealtimes. We observed, both days, on Watergate that people were served a hot meal and sandwiches together on one plate. Staff said they were “Offering choice” but we saw that this distracted and confused people and there was a lot of wasted food. We observed one person licking and trying to eat their place mat but staff did to recognise that this could be a sign that they were possibly still hungry.

Staff that we spoke to had an understanding of the Mental Capacity Act 2005 and what this meant for them in terms of providing care. Staff were able to tell us that some people had "variable capacity", and staff said "it can be fluid: sometimes people can and sometimes people can't make a decision but we try to support them”. Staff were aware that “Everyone is deemed to have capacity unless that we can prove otherwise.” We observed staff trying to seek consent before carrying out a care activity.

We spoke to staff on Northgate unit who had a clear understanding of Deprivation of Liberty Safeguards (DoLS) and were able to tell us about how this affected the people they cared for. Staff on the other units had a less clear understanding of this. Staff told us that this was something that the manager dealt with, they were not sure who had a DoLS in place but thought that it “Was everyone that can’t go out”. We saw that registered manager had made applications to the supervisory body for assessment but not all staff we spoke to on the other units knew or understood the process. We spoke to the registered manager about the need to involve staff in the assessment and application of DoLS so that they have a greater understanding across all units.

Two of the units were for people living with dementia. These were not well designed to aid orientation, observation and independent living. Whilst some bathrooms and individual bedrooms had clear signage, visual clues and personalisation not all did and that would make them not easily recognisable to somebody living with dementia. It was evident that staff were working to improve this. Many bedrooms, particularly on Watergate, were not personalised to enable somebody feel familiar with their own space. We also noted on Watergate that there were two notice boards: one was not completed and the other had the wrong day and weather symbol late in the afternoon (day behind and rain not sun). This meant that people who were living with dementia were not being supported to be orientated in time and day.

We recommend the provider refer to best practice guidance for the development of “dementia friendly” environments.

Staff told us and records showed that they had undertaken a comprehensive induction. A new induction programme has just been started to take into account the new care certificate framework. Staff we spoke with told us there were plenty of training opportunities. We spoke to a new staff member who had been employed as the “home trainer” and was to be based at the service. They had started to speak to staff to identify training needs. Staff told us that they received supervision and appraisal: sometimes

Requires improvement

Is the service effective?

this was one-to-one and other times this was in a group setting. Records supported this. Senior staff felt that supervision could be better and more effective if they had more time to do this with staff.

Requires improvement

Is the service caring?

Our findings

People that we spoke with told us "Staff are great, some are better than others and some are exceptional", "They look after me really well", "I have no complaints whatsoever". Most of the relatives that we spoke to shared this view "They take very good care of her", "My relative is well loved and the staff got so upset while she was poorly. They even went to hospital to see her as they knew she wasn't eating: she loves them and they love her". "I'm generally pleased by the care and staff are always very respectful " I know the staff and they know me we have a good laugh together"

We saw that staff in three of the units showed an awareness of what people liked and how they wanted their care to be provided. We saw that care plans indicated preference of when to get up go to bed and the preferred gender of care staff. People told us that they could sleep in if they wanted to and some people were able to make drinks in their rooms. We spoke to someone who told us how staff had helped them settle in, make their room " Their own" and they were able to keep a small pet for company so it was more like home

We observed that people were mostly treated with dignity and respect. Consent was sought before people's care needs were attended to and staff were discreet in their approach. We saw that people knocked on bedroom doors before they entered rooms and that doors were kept closed during personal care. We saw some positive interactions with people, especially on Northgate, where some people were upset or distressed due to their health needs. Staff were engaging and patient and knew what emotional support people needed in order to support them during a time of distress.

However, we observed on Watergate that people were ignored by care staff on occasions and there were long periods where there was minimum contact or engagement with staff. During the morning, we saw one person sat with a staff member (who was on a laptop) but there were ignored and not acknowledged. They got up after several minutes and left. A few minutes later, the same person returned and sat down in the chair. Once again the person was not spoken and there was no attempt to include them in any conversation. The staff member told us that they were concentrating on a newsletter. Later in the day during a SOFI, we observed that a person with communication difficulties tried, on three occasions, to catch the attention of care staff as they passed though the room but there was no attempt to engage with them. A person sat with their dessert for 55 minutes and was quite distressed. Staff made no contact with them during this period but we saw in their care plan that they "liked one-to-one support and staff need to be encouraging especially when [x] eats". Once a staff member eventually went to assist them, they calmed down and stopped crying for that short period. During our SOFI observation, we saw a staff member, who told us they did not know the needs of people well, refused assistance by other members of the team when they asked. We saw the staff member move a person into a wheelchair, in accordance with their care plan, but they struggled to explain to the person what they were going to do as there was a language barrier. The person was rushed and, if it were not for the intervention of the inspector, the staff member would have run over the foot of the person sat next to them with the wheelchair.

The registered person had not ensured that the needs of individuals were being met and that their welfare and safety was not being compromised. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the concept of equality and diversity and recognised that there were a number of people who used the service and staff that came from a different cultural background. Staff told us it was important not to treat people differently, to accept people for who they are and to respect their wishes. Some people who lived in the home spoke different languages and staff told us how they have used language line the translation service to help them. We also observed the registered manager using an "application" on their phone to find the right translated word. However, we were also told by a person using the service that "Sometimes staff speak in their own language together in front of people and I don't like this because I don't know what they are saying". This meant that sometimes people did not feel included in the conversations being held around them and this was unacceptable practice.

Inadequate

Is the service responsive?

Our findings

There was an activities coordinator who had a number of staff working across the units. There was a variety of activities on offer and these included crafts, quizzes, one-to-one support, and support to go out. We saw that the levels of interaction varied greatly across all the units over the two days. One person told us that "Sometimes activities are held on another unit" and they did not "Feel it was fair that not everyone got the opportunity to attend." We also saw that people were not always encouraged or asked whether they wanted to participate in activities. We saw that only a few people were offered the chance to take part in an Easter cake activity and to have some chocolate. Others were sat during this time with no stimulation. We asked the staff why they had not included everyone and we were told that "We know who will join in and who won't". We also saw on one unit that the television was set all day to a modern pop music channel and people were sat with little other stimulation.

Each person had a care plan where staff documented the care required and received. People were not able to remember if they had been involved in the writing or review of their care plans. Care staff told us that they rarely read care plans unless there was something they were really not sure about and then they would ask the nurse in charge or discuss at handover. Care staff told us that they were not involved in any aspects of care planning such as someone's life story or preferences. One care staff member commented ", it's really sad when you only find out things about them at their funeral."

We also saw on one unit that care staff recorded activity and checks that had not taken place. During a SOFI observation we saw that 9 out of 11 people did not have any engagement with staff or care for the time of our observation. When we looked at the records, we saw that care staff had recorded that a person had been checked when they had not. This meant that staff created false records and did not provide the 2-3 hourly check that was required. We brought this to the attention of the provider who assured us that an investigation would be undertaken. We were informed following the inspection that an immediate investigation had been undertaken and appropriate actions taken with the staff concerned.

We saw that care records did not always provide an accurate picture of the care that needed to be delivered. We saw from medicines records that a person had been prescribed cream "for all affected areas" and the body map and the care plan indicated that it was used for the "sacrum and groin" area. Staff, however, told with us that they were administering it under the breast.

The registered person had failed to ensure that people received care that was appropriate and that records were an accurate reflection of care being given. This was a breach of Regulation 9 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had specific instructions in relation to their care such as food and fluid intake and repositioning. We noted on both days that accurate records were not kept for example, at 4 pm on Bridgegate unit; records for three people had not been completed since 6.20 that morning. When we returned the next day records had then been completed retrospectively. There was a risk that care records would not be an accurate reflection of what had happened and there was a lack of accountability. We also noted the carers often recorded what fluid that had been served rather than what had been consumed. Staff told us about this and told us it was hard to keep accurate records for people who walked around the home over the course of a day.

The registered provider had failed to ensure that people were protected from the risks of unsafe or inappropriate care as there was not an accurate record held in respect of each person. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed on Watergate that people were not supported to wear glasses or items of clothing that promoted their dignity and safety. We saw a person walked around without slippers and odd socks. We spoke to a carer and asked why they didn't have any slippers on. We were told that she should have "but she's probably slung them!". No attempt was made to rectify this. We saw that two people were not supported to wear glasses. A person did not have their

Is the service responsive?

glasses on from 9.30 am until 4.30 pm although their care plan indicated "if staff notice he's not wearing glasses they should find them". We spoke to staff who said they were not sure if this person had glasses any more. We noted another person whose glasses were on the floor during lunch and their care plan stated that "[a] should have them at hand and should be cleaned twice a day". We saw that the glass was dirty and they were left on the table whilst the person was taken to the hairdressers. This meant that people were at risk as they could not see properly. Concerns had been raised with us that someone had lost weight due to them having been without their teeth for three months. We checked records that showed that the person had maintained weight but also that they had their dentures and that these had been marked with their name in February. Subsequent to the inspection, the registered manager confirmed that the person does not have their dentures and staff presumed them missing, so had not sought to replace them. Steps have now been taken to remedy this.

The registered provider had failed to ensure that people were receiving care that was appropriate. Care required to meet individual need and to ensure their welfare and safety was not always delivered. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we heard staff talk to people in an appropriate manner, we also read and heard things that demonstrated a lack of awareness and understanding by staff of how condition's such as dementia impact upon an individual and their behaviours. "His behaviour is bizarre at times he's looking for his parents" "You can't do anything with [x] today" "you've already been told that you cannot have a cigarette until after lunch".

We noted on Northgate unit an overwhelming smell of cigarette smoke. The registered manager and the staff told us that this had been on-going issue since the ban on smoking in confined spaces. A room with a fan and outside access had been designated as the smoking area but the smell still permeated into the building. There had been complaints from staff, residents, relatives and people who visited the service. An outside shelter had been requested by the registered manager in June 2014 and we saw evidence that they continued to push forward the progress and that this had been approved on the 27 February 2015.

The provider had a complaints policy that showed people to how to make a complaint or how to seek resolution should they not be happy with the response. People that we spoke with and their relatives told us that they knew how to make a complaint and confidence that it would be resolved. We spoke to somebody who told us about recent issues about having to get up too early and having preferences for a particular carer they told us that these issues had been successfully resolved after discussion. We saw that the registered manager kept a log of "formal" and informal complaints and responded to both. We saw the response to the two most recent concerns and appropriate actions had been taken and communicated to the complainant.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in place and he had been with the service since May 2014.

People who live at Crawfords Walk and their relatives were complimentary about the registered manager "He is lovely he comes in and says hello every day and I feel I can talk to him and he listens. I asked about putting some pots outside around the garden and he said that was okay it was fine because after all it's my home"," The manager is a real gem is lovely and very much approachable".

There was evidence of team work and good relationships between most of the staff. The senior staff acknowledged that input that the care team have on the units "The carers on here brilliant. I cannot fault them: being the only nurse with them is fine when we are short as they really pull out the stops to help". Staff acknowledged the diverse needs of the people within the home and used their weekly meetings to share ideas and skills. "We really work together on the units because people have different levels of experience. Some people have a great knowledge about physical health issues others in mental health, we work as a team".

The provider had a comprehensive audit system in place that covered all aspects of a person's care and of the building. Audits were carried out at a unit manager, registered manager and provider level. We saw that there were care plan audits in place which had an action plan where gaps were identified. There was also a "resident of the day" and that person would have a full care plan review and audit of their room. However, we saw that some of the concerns raised during the inspection had not been highlighted on these audits. For example, we asked to see records around the use of covert medication for a person. Staff told us that "They're not on that now as they have taken everything for a while; some things had been changed to liquids so the care plan is wrong". We were concerned at these records had only been reviewed on 27 February 2015 and so the care plan audit had not been effective. We saw that the provider had identified a number of areas of improvement in October 2014 and the registered manager was working on an action plan to improve areas of practice. We also directly observed concerns about practice and interaction during our observations. We discussed with the registered manager the need to have a more robust way of directly observing practice and ensuring that issues were challenged immediately by all of the management team.

Opportunities were in place for staff to discuss concerns and for information to be shared across units and departments. These included weekly head of department meetings, weekly clinical risk and daily medication audit sessions. We observed one of the weekly head of dept. meetings and saw that opinions and concerns were shared. We saw that there were discussions about meals, activities and the support of new staff. The role of the new trainer was discussed and also how to support people whose first language was not English. The registered manager also spoke to staff about care issues that affected people such as falls prevention and also keeping dentures safe and named as both had been an issue. The staff team also discussed how male staff from one unit could be used to support another unit as part of a risk management plan. Team Meetings were also evident with staff and these were recorded and shared.

There were also meetings held with people using the service and relatives and this was supplemented by a managers "drop in". Some of the people who used the service and relatives that we spoke with were aware of this but felt that they could approach the registered manager at any time.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People were not protected of unsafe or inappropriate care or treatment arising from the lack of proper or accurate information about them. 17(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People were not protected against the risks of receiving care that was inappropriate. The care required to meet the people's individual needs and to ensure their welfare and safety was not delivered. 9(1)(a)(b)(c)(3)(a)(b)(h)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: People were not protected from the risks associated with unsafe premises and there was a lack of adequate maintenance. 15(1)(a)(b)(c)(d)(e)(2)